EXHIBIT 40

Briones Inquest Testimony

STATE OF WISCONSIN : CIRCUIT COURT : MILWAUKEE COUNTY

CIVIL DIVISION

BRANCH 27

- -

IN RE THE INQUEST INTO THE DEATH OF:

DEREK WILLIAMS Case No.: 12 JD 000027

- -

CONTINUED JURY TRIAL
PM SESSION

- -

February 12, 2013 BEFORE THE HONORABLE

JUDGE KEVIN E. MARTENS

A P P E A R A N C E S:

ATTORNEY JOHN FRANKE, Attorney at law.

PAULINE GARRY, Official Court Reporter

MR. FRANKE: The State calls Dr. Alice Briones.

THE COURT: Okay. Please come forward all the way to the front.

(Witness sworn.)

THE CLERK: Please state your name and spell your first and last for the record?

THE WITNESS: Alice Briones, A-L-I-C-E, B-R-I-O-N-E-S.

THE CLERK: Thank you.

THE COURT: All right. Can we make sure you speak directly into the microphone.

THE WITNESS: Yes, sir.

THE COURT: I think that chair may adjust if you need to either up or down with the lever I think to the left, and then with that, Mr. Franke, you may proceed.

ALICE BRIONES,

called as a witness herein, having been first duly sworn, was examined and testified as follows:

E X A M I N A T I O N

BY MR. FRANKE:

Q. Dr. Briones, how are you currently employed?

A. I am currently a member of the United States Air Force, and I work for the Armed Forces Medical Examiner System.

Q. Where do you work in that capacity?

A. At Dover Air Force Base, Delaware.

Q. Were you in court earlier when Dr. Peterson talked about the Armed Forces Medical Examiner office?

A. Yes, sir.

Q. I don't remember exactly how he characterized it, but is that the same office that you now work for a few years later?

A. Yes, it's been renamed. It used to be the AFIP, sir.

Q. Say that again?

A. It used to be the Armed Forces Institute of Pathologist, and it has been since renamed.

Q. I'm going to hand you Exhibit 221. Can you tell us what that is?

A. Yes, sir. This is my CV or curriculum vitae.

Q. Would you summarize it starting with any involvement that you had with the military, when that started, and how it relates to your work as a medical doctor?

A. Yes. I joined the military at age 17, joined the Army Reserves, used that to pay for school which I went to the

that type of thing.

Q. And clinical generally is what?

A. Reading -- if people need blood products in the hospital, hematic pathology, for example, looking at blood smears, chemistry tests, toxicology, for example.

Q. The residency -- you mentioned the university, but what was the university and in what city was it in?

A. Rochester, New York, it was at Strong Memorial Hospital.

Q. What did you do after that residency?

A. I did a fellowship in a subspecialty in pathology called forensic pathology. I did that at the Office of the Medical Investigator in Albuquerque, New Mexico.

Q. How long was that?

A. 1 year.

Q. What do you mean by the term forensic pathology?

A. Forensic pathology is the use of pathology in the investigative medical and legal terms to investigate cause and manner of death.

Q. What did you do after Albuquerque?

A. After finishing my fellowship, I moved to Dover, Delaware, where I became active duty air force at Dover Air Force base at the Armed Forces Medical Examiner System as a deputy medical examiner?

Q. Is that what you are doing now?

A. Yes.

A. The diagnosis, verifying the diagnosis of the decedent if they had had that while they were living, either sickle cell or sickle cell trait or disease, and also being able to diagnose that in the postmortem interval being able to --

Q. Do you know -- I'm sorry, go ahead.

A. -- to verify that.

Q. Do you know whether the three cases you had connection to involved a deceased person with sickle cell disease or sickle cell trait?

A. One case had sickle cell disease, two of the cases had sickle cell trait.

Q. How many medical doctors are employed at the Dover Air Force Base or are connected to the whole Armed Forces Medical Examiners System?

A. Within the office located at Dover, it's 13, but then we also have regional medical examiners throughout the country, and that's another I think about 5 to 8, but actually at the central office it's 13.

Q. Did you conduct a review of some sort of the Derek Williams' autopsy that occurred here in Milwaukee, Wisconsin?

A. Yes.

Q. How did it come about that that matter came to you out in Delaware?

A. Our office after we received a request from the FBI. to perform a case consultation for review of the materials that we were presented.
Q. Did you perform an actual autopsy in anyway on Derek Williams?
A. No.
Q. What is it that you did do?
A. I reviewed the materials that were forwarded to us which included an autopsy report, several videos, a report of the hyoid bone, a report -- the slides, the actual microscopic slides from the case, the toxicology reports, and police investigation reports.
Q. Did you also review the video of Derek Williams in the back of a squad car?
A. Yes.
Q. I'll hand you what is Exhibit 209, can you tell us what that is?
A. Yes, Exhibit 209 is the copy of my final case consultation report.
Q. I meant to ask you before we got to the report that you indicated that you were asked by the FBI to do this, do you know how it got to you within the medical examiners office?
A. I was selected to review the case as to do the case consultation. I do have some interests in some areas of

Q. What's the procedure that you followed within your office to conduct the case consultation that's reflected in the report in front of you?
A. With all the case consultations, I do a thorough review of what was presented to us as already having been accomplished. The initial autopsy report, the revised autopsy report, I went through and looked at the slides to make my own opinions. I went through all of the investigative information that was given to me including the toxicology and all of the medical records and everything that was given to me and came up with a basic list of what do we need further to come up with conclusions.
Q. What happens next then in terms of your procedure?
A. With a complex case such as this, I would bring all of the materials I had, including my conclusions, and present them to our staff case consensus conference in which all of the medical examiners would be presented from me what I found with this case.
Q. At the time of that conference, did you have some conclusions either final or tentative?
A. Yes.
Q. Tell us about that?
A. At the time of the initial -- the initial case conference, I had a list of questions that would lead us

to rule in or rule out some things for cause and manner of death, some of which were then in need for further medical records, the need for an extended toxicology report, and we presented those at the conference, and everybody at the conference agreed that these were some items that we needed further information on to come up with some answers.

Q. Explain what you mean by this conference, and who's involved in it, and whether it's done in all cases or just some cases?

A. At our office we do have 100 percent QC, but this conference is equivalent to what Dr. Peterson referred to earlier of the basic difficult case conference.

When you have a case with a lot of complexity, you would bring it to all the other staff pathologists who would be present with different levels of experience and with difference types of cases, and they would be able to offer expertise or suggestions on ways to approach the case.

Q. How many medical doctors participate in this -- I want to use the right term -- is this a consensus conference?

A. Yes.

Q. How many medical doctors participate in this?

A. Due to the fact that we are high ops with missions on average 9 to 10 docs, because we can never get all 13

docs usually at the same time in one room, so it's generally 9 to 10 docs that are present for a case consensus conference.

Q. I just want to make sure that the reporter is getting it and also that we understand some of the terms that you used, did you say "high ops"?

A. Yeah, "high ops" in terms of operations tempo, I apologize.

Q. What does "high ops" mean or stand for?

A. Just that we may be out of the office short notice to go on a mission within the United -- we can get called the night before to go somewhere for a case the next day, so we may not be in the office when we say -- or the day before we'd be at a meeting, for example.

Q. You travel a lot in connection with your work?

A. Yes.

Q. To what extent when you're working on a cases are bodies brought to you as opposed to you having to go to the body?

A. Bodies from oversees are brought, remains are brought to Dover. But if a decedent is -- or dies, for example, on location state side, we will go state side to make it easier for them to make arrangements.

Q. We got off on to this because of the phrase high ops, I just wanted to make sure that I'm picturing what it means

when you're saying high operations.

A. High tempo I guess or high speed, just being able to go at the drop of a hat.

Q. The phrase in your office that you use for this though is you used the phrase high ops?

A. High ops tempo is what we use. I perhaps should have maybe not use that term, I'm sorry.

Q. All right. Back to the consensus conference, do the people in this conference listen to you, do they review everything themselves, how does it work?

A. They listen to my presentation of the case and the materials that I've reviewed. We come up with a list of suggestions and questions on where to go to next.

In terms of actual materials to review, all pictures are reviewed by all the doctors at the case consensus conference, as are the slides, the pathology slides, microscopic sections.

Q. After this first consensus conference, was there any attempt to reach a decision about the cause of death and manner of death or was it just dealing with the need for more information?

A. It's namely focused on the need for more information to come up with any conclusions.

Q. And tell us again what your tentative conclusions were at that time?

Q. And just to finish with this atropine, what's the significance of that?
A. Most likely due to a life saving treatment measures, attempted life saving treatment measures.
Q. So you have some medical records for Derek Williams, you got new toxicology reports, where do you go from there?
A. We did a thorough review of also the police report, and I re-presented one -- I had all of the information including the toxicology report to the consensus conference at a later date and re-presented all the information to the same conference.
Q. Let's go back to looking at the slides, the histology, is that something you did before the first consensus conference?
A. Yes, that is.
Q. Indicate how many slides you had and what review you conducted of them?
A. There were nine histology slides reviewed, representing all of the different tissues or organs within the body.

I made my review of those and compared my findings in comparison to what was seen by the initial report that we received, and I presented that to -- at the first consensus conference.
Q. When you look at the slides, are you looking at them under a microscope?

A. Yes.
Q. And do you actually look through the microscope or are you now looking at them produced on some monitor?
A. We actually look at them on a microscope. They can be projected, but we look at them through the microscope to make any diagnoses.
Q. And when you look at a slide, are you looking at just random selected sections of the slide or do you have some other procedure?
A. Routinely when looking at tissue on a slide like Dr. Peterson held up and showed you earlier, it's a piece of tissue with a lot of little cells, so you have to scan thoroughly throughout the whole slide. It's your obligation as a pathologist to make sure that you look at all the tissue on a slide, that can take time.

You can do that at low power so it looks a little further away. And if there's an area of interest, something that you want to look at a higher power, you can focus in on that at a higher power, but you scan through all the tissue on the slide.
Q. When you're looking at it at the -- I guess it will be a lower power, a larger area, examining this kind of tissue, I'm trying to get an understanding for whether you are looking at a big chunk of what's on the slide or just a tiny fraction of it?

A. The ultimate goal is to review all of the tissue, but in one focus you're looking at a small part of that tissue just because that's the field, and that side of that field depends on if you're looking at 40X or 20X power magnification of the field that you're looking at.

Q. How do you know if you're looking at all of what is under the microscope on that slide?

A. You should be able to tell if you are within the whole tissue by the cells that are there and the order of the tissue, et cetera.

Q. And did you review all of each of these slides?

A. Yes.

Q. What did you see or conclude based on your microscopic examination of the slide?

A. The majority of the organs that were examined had prominent vascular congestion, which basically means the vessels in each tissue were very full of red blood cells, a lot of them, and we don't always see that in every case. We also saw a lot of pigmented cells in the lungs which were there on the first autopsy report as well.

Q. Say that last part again, what type of cells?

A. Pigmented cells.

Q. Did you see in your observations what you believe to be sickle cells?

A. We saw numerous red blood cells that were dysmorphic,

some of which could be called sickled. It had a change in shape. They weren't their usual shape, they were dysmorphic.

Q. When you say "we," first tell me what you saw? Did you see that?

A. Yes, I saw that.

Q. When you discussed this with the consensus conference, it's your understanding that these folks had all looked at the same slides?

A. They did.

Q. And if you remember this particular case, how many medical doctors were included in that process?

A. 9 to 10 between the two consensus conferences.

Q. I am going to put Dr. Poulos' first autopsy report up, at least a part of it. This is from the second to the last page. It indicates the microscopic description for the heart and coronary arteries and the lungs. Are you able to read it from there?

A. Yes.

Q. I can give you have the hard copy with the first report if that would help. This is Page 8 of the report. Some of this has been read to the jury before. I don't know that we need to read it again, but just starting with the heart and coronary arteries, do you agree or disagree with that description of what is seen in the microscopic

examination?

A. I agree that there are numerous blood vessels that are filled with red blood cells that are different in shape or dysmorphic. Some of those could be described as sickled. The vessels were full, but we didn't agree with the term occluded.

Q. What does the term occluded mean to you?

A. Completely blocked off. The vessel is completely basically like stopped off, like a cork or something completely blocking it off.

Q. If you assume that the term aggregate of sickled red blood cells means thrombi, do you agree with that description?

A. I agree that there are aggregates of red blood cells. I don't agree that they are formed in the thrombi. I don't see the elements of what a true thrombus is made of in these slides.

Q. Anything else in the heart or coronary artery section that you agree or disagree with or have you covered that?

A. I think we covered it, sir.

Q. Let's get the lungs up separately here.

With respect to the lungs -- I guess I get two or three tries with my iPad. If I don't get it right, then it kicks me out. I'm trying to explain to the jury why I have handed the iPad to my assistant to get it back.

Under the lung section, can you tell us what you agree with or disagree with?

A. I agree with the marked vascular congestion and that there are aggregate of cells that I describe as dysmorphic, some of which do appear somewhat sickled, but they're all changed in shape.

I also agree with the statement in the initial report saying that there were numerous pigment-laden macrophages.

Q. Now is this something different than what has been written for the heart and coronary arteries?

A. Yes, the last statement about the pigment-laden macrophages is different.

Q. And what does that matter do?

A. Macrophages are basically like kind of clean-up cells. They come in and eat up all the different junk, so they kind of have pigments in them, and you can see them in various organs in the body, but in the lungs they can be associated to smoking, for example.

They can be associated -- they can sometimes be called heart failure cells, but they are often associated with smoking.

Q. Is this a different issue than the question of whether any cells were sickled or dysmorphic?

A. Yes.

Q. Did this statement suggest any possible concern with respect to cause of death for you?

A. No.

Q. Let's go to the last page where we have a description for several organs. It may not be readable from the jury's distance, but we'll put it up here in one screen.

Can you summarized the extent to which you agree or disagree with the findings of Dr. Poulos concerning the other organs?

A. I agreed with the evaluation of the liver and pancreas, and the same comment came up before with the spleen and kidneys. Particularly we disagree with the use of the word distension in describing the vascular in the spleen.

There was congestion, so if you have a vessel with a -- if you have a vessel with a lumen, it can be full. The lumen can be full of a substance such as red blood cells.

If it were to be distended, think of the lumen or the outer part being stretch. He didn't experience that. There was a congestion -- or inside of the lumen was full of red blood cells that had different shapes, but I did not appreciate that the actual vessel was stretched like an elastic or distended.

Q. Now, I'll put this section up we've been discussing up on the screen. The statement as to the liver, does that

suggest that there was not the same kind of aggregation of sickle cells in the liver that there was in other organs?

A. Yes.

Q. Did you agree or disagree with that?

A. I agreed.

Q. The spleen then has a reference to the marked vascular distension by aggregates of sickly red blood cells. Other than the disagreements you've already referenced, did you agree in a sense that the cells in the spleen seem to be -- the red blood cells seem to be different than in the liver?

A. Yes.

Q. The pancreas is listed as not demonstrating significant pathologic changes, do you agree with that?

A. Yes.

Q. Kidneys, now again as to the kidneys, it is indicated that they are remarkable for aggregates of sickled red blood cells, occluding numerous vascular spaces. Other than the issues that were already addressed about occlusion and whether they were sickled or not, did you agree that there was a difference between -- for the red blood cells in the kidneys as opposed to the liver?

A. Yes.

Q. The central nervous system, do you understand what the

area of the body Dr. Poulos was referring to in this section?

A. Yes.

Q. And what does that include?

A. Central nervous system consist of the brain, the spinal cord.

Q. Did you agree that there were dysmorphic red blood cells in the central nervous system?

A. Yes.

Q. At the second case conference, the second consensus conference, what was your opinion as to cause of death?

A. My opinion was based on everything reviewed, it was undetermined due to the fact that we could not pinpoint one single cause of death.

Q. Did you present that opinion to the others at the conference, is that how this would work?

A. Yes.

Q. What was the opinion of the consensus conference?

A. The unanimous opinion was undetermined as well.

Q. Either before or after the second conference, had any other causes of death besides sickle cell crisis of some sort been considered?

A. They had been considered but ruled out by the expanded toxicology panel.

Q. I am going to hand you Exhibit 250. Do you recognize

A. There were a few issues, one of which was what we were seeing microscopically. We agreed that the cells looked dysmorphic, may be described as sickling. We could not definitively conclude was that sickling due to an actual problem with sickle cell trait or was it due to a postmortem heart attack, or was it due to the events that did lead to Mr. Williams' death?

Was it due to the fact that he had a lack of oxygen? Was it due to that fact that he had physiological stress? Was it due to the fact that he was dehydrated? We couldn't definitively answer those questions.

Q. In explaining your conclusions, does Paragraph 2 on Page 3 that I just highlighted for the jury explain this conclusion?

A. Yes.

Q. Why don't you just read that paragraph which continues on the next page, but read the portion that the jury is looking at.

A. "After review of the microscopic slides, the Office of the Armed Forces Medical Examiner agrees with the diagnosis of vascular congestion, but cannot comment on the significance of the dysmorphic red blood cells within the vessels of multiple organs. No true/distinct thrombi with fibrin strands are identified in any of the histologic sections examined. The significance of the

dysmorphic red blood cells in post mortem histology is difficult to discern.

The red blood cells may appear 'sickled' or 'dysmorphic' due to postmortem artifact or underlying disease. The exact cause of the dysmorphic red blood cells in this specific case is unknown based on the amount of information reviewed and the decedent's history of Sickle Cell Trait. The decedent's diagnosis of sickle cell trait should be considered as a contributing factor, but it is difficult to discern the exact cause of death based on the investigative" --

Q. I need to go to the next page, and I probably should have told the jury before that while there may be some descriptions on the exhibits likes these autopsy reports and Dr. Briones' report, you'll have access to these, so you don't need to try to take down notes while we're doing this. You'll be able to have this to review later.

Let's go to the continuation of this paragraph on the next page. You have the hard copy in front of you doctor, correct?

A. Yes, sir. Do you want me to continue?

Q. Just a moment. Go ahead and read the next paragraph, the continuation of same paragraph.

A. -- "investigative autopsy, and toxicology findings reviewed. Review of the medical records, autopsy reports

and microscopic slides did not reveal a chronic pattern of sickle crises as may be evidenced by frequent hospitalizations or organ damage. Because death itself involves hypoxia, hypoperfusion, and other processes that could initiate sickling, differentiating whether sickling occurred in the immediate ante mortem period or in the postmortem period is difficult. Other circumstances such as exertion, physiologic stress, dehydration, altitude, asthma, and other comorbidities may cause red blood cells to appear dysmorphic even in cases of individuals who do not have a history of sickle cell trait. It can be difficult to discern whether the decedent's sickle cell trait or other factors may have caused red blood cells to appear dysmorphic in this case."

Q. I think we may be operational again. I wanted to ask you about something that was written in the first part of that paragraph. Where it says "no true/distinct thrombi with fibrin strands," what do you mean by that, and what is the significance of that?

A. Fibrin strands are -- you can think of them as glue that kind of make a blood clot stick together. So when someone describes an aggregate of blood cells, you could have a bunch of red blood cells where they're kind of just together but not stuck together like glued together.

When you have a true blood clot which can be seen,

you can have fibrin strands which organize and kind of hold those red blood cells together like glue.

Q. How does the term thrombi compare with the more common sense or common analogy term like clot?

A. People think of thrombi as perhaps smaller clots, but they are thought of as clots, blood clots basically.

Q. And to be in your view a true or distinct thrombi, does that require fibrin strands?

A. It is a disputed issue, but yes.

Q. As applied to this case, what is the significance of your statement that no true thrombi with fibrin strands are identified?

A. Although there was vascular congestion, we did not see blood clots or thrombi that blocked off the tissues, the vessels from getting oxygen to the tissues such as the spleen or other organs. If that were to happen, especially someone who may have had repeated crises, you could see an organ damage because the oxygen didn't get to those organs because of a clot, for example.

Q. The next sentence that you read earlier, does that identify a different problem and that is distinguishing between dysmorphic red blood cells or sickle cells that may have occurred after death as opposed to before death?

A. Yes.

Q. And what is your understanding of that issue?

packing of distended hepatic sinuousoids (phonetic) by dense plugs of sickled erythrocytes is the most reliable indicator of an ante mortem process. Do you remember you read that this morning?

A. Yes.

Q. What is your opinion as to how this article and this particular section bears on the question of whether pathologist are able to distinguish generally between sickling after death and sickling before death?

A. I think this is one article that refers to one organ specifically here, the liver, that they're referring to, they're kind of using it as a guideline. I think that there are a lot of new studies in the works, this one is dated 2009. There are some that are more current articles that have already been referred to.

Again this topic is something to consider, to use as a tool, for example, as this article says to help you try to make a decision, but it is not a clear cut if you have distended vasculature in the liver, then it's obviously an ante mortem event.

Q. This article as citing some other authors indicates that this might be the most reliable indicator of the before death process. Are you aware of any studies that have been done that indicates any other indicators of distinguishing between ante mortem and postmortem

sickling?

A. Some of the other studies have been referred to earlier, the Kark studies have done -- I don't know the details of all of those studies, but there are a lot of studies in the works because this is such a precarious issue that people are trying to find a way to better represent when sickling occurs.

Q. And aside from perhaps in cases like this, helping someone decide what the cause of death is, is this important in trying to figure out the extent of the risks that someone with sickle cell trait has of suffering a sickling of the cells that's important, not just after death as a consequence of death, but something that might be a medically important event before death?

A. I'm sorry, I'm not sure I understand the question.

Q. I'm not sure I did either.

You have referred to this as being somewhat controversial in the medical profession. Is this just a question of controversy over determining whether people have died of sickle cell crisis in a person with sickle cell trait or does it go beyond that?

A. I believe it goes beyond that, it's determining the significance of finding dysmorphic or sickled red blood cells on slides in autopsy reviews.

Q. In addition to the conclusion that the cause of death was